

VISION SCREENING PROGRAM REPORT

PLEASE PRINT AND TOTAL ALL COLUMNS

NAME OF SCHOOL	DISTRICT:	COUNTY:
SCHOOL ADDRESS	CITY:	ZIP CODE:
PLEASE PRINT		
SCREENING PERFORMED BY	SCHOOL YEAR: 2004 - 2005	

	DISTANCE ACUITY			NEAR ACUITY			OCULAR ALIGNMENT			COLOR DEFICIENCY			OUTCOMES		
GRADES	STUDENTS SCREENED	STUDENTS REFERRED FOR 2ND SCREENING	STUDENTS REFERRED FOR EVAL- UATION	STUDENTS SCREENED	STUDENTS REFERRED FOR 2ND SCREENING	STUDENT REFERRED FOR EVAL- UATION	STUDENTS SCREENED	STUDENTS REFERRED FOR 2ND SCREENING	STUDENT REFERRED FOR EVAL- UATION	STUDENTS SCREENED	STUDENTS REFERRD FOR 2 ND SCREEN- ING	STUDENTS IDENTIFIED WITH COLOR DE- FICIENCY	STUDENTS REFERRED TO EYE CARE PRO- FESSIONAL	STUDENTS THAT RECEIVED CARE FROM EYE CARE PRO- FESSIONAL	STUDENTS NOT SEEN OR LOST TO FOLLOW UP
PRE- SCHOOL															
KINDER- GARDEN															
1 st															
2 nd															
3 rd															
4 th															
5 th															
6 th															
7 th															
8 th															
9 th															
10 th															
11 th															
12 th															
SPECIAL EDU- CATION															
OTHERS															
TOTALS															

Recommended Screening:

- Children ages 9 years and younger (Includes pre-school thru 3rd Grade)
 - Distance Visual Acuity
 - Stereopsis
 - Color Deficiency (only if required by school district)
- Children ages 10 years and older (Includes Students in 4th, 5th and 6th Grades)
 - Distance Visual Acuity
 - Near Visual Acuity (only where required)
- All new students
- All students receiving Special Education Services
- Students referred by a parent, teacher, or other professional

**PLEASE COMPLETE AND SUBMIT THIS REPORT FORM TO ADHS BY
JUNE 30TH OF THE CURRENT SCHOOL YEAR.**

MAIL REPORT TO

ADHS/OWCH SENSORY PROGRAM
150 North 18th Avenue, Suite 320
Phoenix, Arizona 85007-3242
(602) 364-1400

FORM COMPLETED BY (If not Screener): _____